on-site X-ray services.

K. Pharmacy and immunization costs shall be reimbursed through the Title XIX pharmacy program utilizing current fee schedules established for those services. These costs shall be reported in the cost report under non-allowable services, and product costs shall be adjusted out. Costs relating to contracted pharmacy services shall be reported under non-allowable services, and adjusted out in full.

L. Costs relating to the following services are excluded from the encounter rate and shall be reported in the cost report under non-allowable services.

1. Ambulance services;
2. Home health services;
3. WIC certifications and recertifications;
4. Any health care services rendered away from the center, at a hospital, or a nursing home. These services include off site radiology services and off site clinical laboratory services. However, the health care rendered away from the center may be billed under other Medicaid programs, if eligible.

M. Under no circumstances shall any encounter rate exceed the reimbursement ceiling established. Any rate established prior to January 1, 2001 shall not be adjusted.

V. Method

This section defines the methodologies to be used by the Florida Medicaid Program in establishing reimbursement ceilings and individual FQHC and RHC reimbursement encounter rates.

A. Setting Reimbursement Ceilings

The reimbursement ceiling shall be established and applied to all new providers entering the Medicaid program on or after January 1, 2001. The reimbursement ceiling shall be calculated by taking the sum of all the prospective rates divided by the number of providers in the Medicaid program.

B. Medicaid Prospective Payment System

For the new Medicaid Prospective Payment System (PPS), January 1, 2001 through September 30, 2001, Medicaid will compute a base rate for current FQHCs and RHC's by taking the average of their Medicaid rates set by the center's fiscal year 1999 and 2000 cost reports. Beginning October 1, 2001 and every October 1 thereafter, the rate will be increased by the percentage increase in the Medicare Economic Index (MEI) for primary care services for that Fiscal Year.

C. Setting Individual Center Rates – FQHC

1 For new providers entering the program on or after January 1, 2001, the initial rate shall be established by taking an average of the rates for centers in the same county or district with similar caseloads.

2. In the absence of centers in the same county or district, with similar caseloads, establish a cost-based encounter rate by cost reporting methods.

a. Review and adjust each FQHC's cost report available to AHCA to reflect the results of desk and field audits.

b. Determine each FQHC's encounter rate by dividing total allowable cost by total allowable encounters. (See Section XI for definition of allowable encounters).

3. Establish the initial prospective encounter rate for each FQHC as the lower of the cost-based rate established in V.C.2 above or the ceiling established in V.A above.

4. All subsequent prospective encounter rates shall be determined every October 1 by multiplying the initial prospective encounter rate by the MEI for primary care services for the Fiscal Year.

D. Setting Individual Center Rates- RHC

1. For new providers entering the program on or after January 1, 2001, establish an initial encounter rate by using the current Medicare rate established by the Title XVIII Medicare carrier.

2. Establish the prospective encounter rate for each RHC as the lower of the initial encounter rate determined in 1 above or the ceiling established in V.A above.

3. All subsequent prospective encounter rates shall be determined every October 1 by multiplying the initial prospective encounter rate by the MEI for primary care services for the Fiscal Year.

E. Providers experiencing an increase or decrease in their scope of service(s) may request a rate adjustment in accordance with Section IV(E). Approved rate adjustments will be added to their prospective encounter rates on the effective date of the rate adjustment.

VI. Supplemental Payments

When the payments to the provider under the managed care organization contracts are less than the provider's Medicaid rates, quarterly supplemental payments will be made to the provider. The amount of the quarterly supplemental payments will be the difference of the managed care organizations payment to the FQHC or RHC and the Medicaid Rate.

VII. Payment Assurance

The State shall pay each FQHC and RHC for services provided in accordance with the requirements of the Florida Title XIX State Plan and applicable State and Federal rules and regulations. The payment amount shall be determined for each FQHC and RHC according to the standards and methods set forth in the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

VIII. Provider Participation

This plan is designed to assure adequate participation of FQHCs and RHCs in the Medicaid Program, the availability of FQHC and RHC services of high quality to recipients, and services which are comparable to those available to the general public. This is in accordance with 42 CFR 447.204 (2000).

IX. Revisions

The plan shall be revised as operating experience data are developed and the need for changes is necessary in accordance with modifications in the Code of Federal Regulations.

X. Payment in Full

Participation in the Program shall be limited to FQHCs and RHCs which accept as payment in full for covered services the amount paid in accordance with the Florida Title XIX Federally Qualified Health Center and Rural Health Clinic Reimbursement Plan.

XI. Definitions

A. Acceptable Cost Report - A completed, legible cost report that contains all relevant schedules, worksheets and supporting documents.

B. AHCA - Agency for Health Care Administration, also known as the Agency.

C. Encounter - A face-to-face contact between a recipient and a health care professional who exercises independent judgment in the provision of health services to the individual recipient. For a health service to be defined as an encounter, the provision of the health service must be recorded in the recipient's record and completed on site. Categorically, encounters are:

1. Physician. An encounter between a physician and a recipient during which medical services are provided for the prevention, diagnosis, treatment, and rehabilitation of illness or injury.
2. Midlevel Practitioner. An encounter between a ARNP or a PA and a recipient when the ARNP or PA exercises independent judgement in providing health services.

3. Dental. An encounter between a dentist and a recipient for the purpose of prevention, assessment, or treatment of a dental problem, including restoration.
4. Mental Health. An encounter between a licensed psychologist or LCSW and recipient for the diagnosis and treatment of mental illness.

D. Budgeted Rate – For new providers, a reimbursement rate that is calculated from budgeted cost data and is subject to cost settlement.

E. Cost Reporting Year - A 12-month period of operation based upon the provider's accounting year.

F. Eligible Medicaid Recipient - Any individual whom the agency, or the Social Security Administration on behalf of the agency, determines is eligible, pursuant to federal and state law, to receive medical or allied care, goods, or services for which the agency may make payments under the Medicaid program and is enrolled in the Medicaid program. For the purposes of determining third party liability, the term includes an individual formerly determined to be eligible for Medicaid, an individual who has received medical assistance under the Medicaid program, or an individual on whose behalf Medicaid has become obligated.

G. CMS-Pub. 15-1 - Also known as the Provider Reimbursement Manual, published by the Department of Health and Human Services, the Centers for Medicare and Medicaid Services. This manual details cost finding principles for institutional providers for Medicare and Medicaid reimbursement, and is incorporated by reference in Rule 59G-6.010, F.A.C.

H. HHS - Department of Health and Human Services

I. Rate Period – October 1 of a calendar year through September 30 of the next calendar year.

J. Title XVIII - The sections of the federal Social Security Act, 42 U.S.C.s 1395 et seq., and regulations thereunder, that authorize the Medicare program.

K. Title XIX - The sections of the federal Social Security Act, 42 U.S.C.s 1396 et seq., and regulations thereunder, that authorize the Medicaid program.